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Thirteen Things Physicians and Patients Should Question

1 Do not use atypical antipsychotics as a first-line intervention for insomnia in children and youth.

Recent research confirms a dramatic increase in the use of atypical antipsychotics with subsequent side-effects including obesity, which is already a major health issue. It is prudent to pursue nonpharmacological measures first, such as behavioural modifications and ensuring good sleep hygiene (such as eliminating daytime napping and shutting off electronics an hour before bedtime). If these interventions are not successful, then consider short-term use of melatonin.

2 Do not use SSRIs as the first-line intervention for mild to moderately depressed teens.

Evidence clearly indicates that antidepressant medication is less effective in children and adolescents up to the age of 17 years and first-line treatment for this group should include cognitive behavioural therapy or interpersonal psychotherapy. Attention should always be focused on children's and teens' environmental safety and adequate parental support to avoid missing cases of neglect or abuse. Following this, a first-line intervention should be psychoeducation on the importance of regular sleep, diet and exercise to ensure healthy, age-appropriate developmental support.

3 Do not use atypical antipsychotics as a first-line intervention for Attention Deficit Hyperactivity Disorder (ADHD) with disruptive behaviour disorders.

Treatment of ADHD should include adequate education of patients and their families, behavioural interventions, psychological treatments and educational accommodations first. If this approach is not sufficient, stimulant medication and a behavioural analysis to ensure appropriate support from the parent and classroom is indicated. The use of alpha 2 agonists (such as guanfacine) and atomoxetine should be considered before using atypical antipsychotics (such as risperidone) in children with disruptive behaviour disorders (oppositional defiant disorder, conduct disorder).

4 Do not use psychostimulants as a first-line intervention in preschool children with ADHD.

Preschool children with ADHD need to be assessed for other neurodevelopmental disorders and consideration given to environmental stressors such as neglect, abuse or exposure to domestic violence. Treatment also includes adequate education and support of parents followed by advice on behavioural management and community placement.

5 Do not routinely use antipsychotics to treat primary insomnia in any age group.

Second-generation antipsychotics (SGAPs), such as olanzapine and quetiapine, have sedative properties, and are often prescribed off-label for complaints of insomnia. These drugs carry significant risk of potential side-effects including weight gain and metabolic complications, even at low doses used to treat insomnia. In patients with dementia, they can also potentially cause serious side-effects of increased risk of cerebrovascular event and increased risk of death.

6 Do not routinely order qualitative toxicology (urine drug screen) testing on all psychiatric patients presenting to emergency rooms.

Qualitative urine toxicology testing has not been shown to improve the routine management of psychiatric patients in emergency rooms because of the potential for false positives, false negatives, true positives which are unrelated or minimally relevant to the clinical presentation, and finally the delay in psychiatric assessment and management as a result of testing.

7 Do not routinely use antidepressants as first-line treatment for mild or subsyndromal depressive symptoms in adults.

Antidepressant response rates are higher for depression of a moderate to severe nature. For mild or subsyndromal depressive symptoms a complete assessment, ongoing support and monitoring, psychosocial interventions and lifestyle modifications should be the first lines of treatment. This may avoid the side-effects of medication and establish etiological factors important to future assessment and management. Antidepressants are appropriate in cases of persistent mild depression, where there is a past history of more severe depression, or where other interventions have failed.

8 Do not routinely order brain neuroimaging (CT or MRI) in first episode psychoses in the absence of signs or symptoms suggestive of intracranial pathology.

Signs and symptoms suggestive of intracranial pathology include headaches, nausea and vomiting, seizure-like activity, and later-age of onset of symptoms. Multiple studies have found that routine neuroimaging in first episode psychoses does not yield findings which alter clinical management in a meaningful way. The risks of radiation exposure and delay in treatment also argue against routine neuroimaging.

9 Do not routinely continue benzodiazepines initiated during an acute care hospital admission without a careful review and plan of tapering and discontinuing, ideally prior to hospital discharge.

Benzodiazepines, while helpful for short-term relief of anxiety and insomnia, are associated with a variety of side-effects and long-term problems including cognitive and psychomotor impairment as well as abuse and dependence. Benzodiazepines are commonly used in hospital to treat anxiety or insomnia in association with either the presenting condition or the hospital environment. Once the presenting condition is treated, benzodiazepines should be tapered and discontinued. For patients who are still on benzodiazepines at the time of discharge, a plan for tapering and discontinuing them after discharge should be completed and specified in the discharge summary and prescription.

10 Do not routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms.

The concurrent management of psychiatric illness and alcohol use disorders requires evaluation of the role alcohol plays as a causative factor for depressive symptoms. Studies have found that response rates to antidepressants are higher when antidepressants are reserved for persistence of symptoms after a period of sobriety lasting from two to four weeks. Additionally, studies have demonstrated remission from depressive symptoms with sobriety in the absence of antidepressant treatment in a significant percentage of cases. Management of comorbid psychiatric illness and substance use disorders including alcohol dependence involves assessment and treatment delivered in a concurrent manner.

11 Do not routinely prescribe high-dose or combination antipsychotic treatment strategies in the treatment of schizophrenia.

High-dose and combination strategies involving atypical antipsychotics (AAPs) are used in clinical practice for patients with schizophrenia who are inadequately controlled with one or more AAPs used at standard doses. A recent meta-analysis found no clinically significant improvements in patients with schizophrenia who were inadequately controlled on standard-dose antipsychotics when treated with combination or high-dose AAPs. In terms of safety, no clinically significant differences were evident between combination or high-dose therapy in comparison with standard-dose monotherapy.

12 Do not use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.

People with dementia often exhibit challenging behavioural symptoms such as aggression and psychosis. In such instances, antipsychotic medicines may be necessary, but should be prescribed cautiously as they provide limited benefit and can cause serious harm, including premature death. Use of these drugs should be limited in dementia to cases where nonpharmacologic measures have failed, and where the symptoms either cause significant suffering, distress, and/or pose an imminent threat to the patient or others. A thorough assessment that includes identifying and addressing causes of behaviour change can make use of these medications unnecessary. Epidemiological studies suggest that typical (i.e., first generation) antipsychotics (i.e., haloperidol) are associated with at least the same risk of adverse events. This recommendation does not apply to the treatment of delirium or major mental illnesses such as mood disorders or schizophrenia.

13 Do not use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia.

Nonpharmacological interventions such as cognitive behavioural therapy and brief behavioural interventions have proven benefit in the management of insomnia in older adults. Epidemiological studies have shown that the risk of motor vehicle accidents, falls and hip fractures leading to hospitalization and death can more than double in older adults taking benzodiazepines and other sedative-hypnotics. Prescribing or discontinuing sedative-hypnotics in hospital can have substantial impact on long-term use. These potential harms and others such as impaired cognition need to be recognized when considering treatment strategies for insomnia. Use of benzodiazepines should be limited to as short a period as possible, in cases where nonpharmacological therapies have failed, and the symptoms of sleep disturbance cause significant suffering or distress.

Top Ten Sleep Tips (as a starting point for discussion/argument)

1. Get up at the same time EVERY DAY (including weekends)
2. Got to bed at the same time EVERY DAY (including weekends)
3. NO napping during the day
4. If you cannot fall asleep within 20-30 minutes, *get out of bed* and go to another room. Do something boring and non-stimulating

Note: During this time do NOT watch TV and do NOT play/work on a computer/phone

Consider some light reading (e.g. magazine, novel) or playing solitaire. Then, when you feel sleepy again, go back to bed. If you have a problem/frustration you can't get out of your head write down the first steps you could do the next day to try to address this.

5. If you wake up during the night and cannot fall back asleep within 20-30 minutes, *repeat number 4*
6. Use your bed and bedroom ONLY for sleep
7. Exercise during the day, but NOT intense exercise within 2-3 hours of going to bed
8. NO caffeine after noon
9. *Limit* alcohol, particularly near bedtime
10. Develop a bedtime routine. Do the *same* things in the *same* order at the *same* time each night before going to bed